DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 03-02	2. STATE Minnesota
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE January 1, 2003	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR §447.252	7. FEDERAL BUDGET IMPACT: a. FFY '03 ($1,083) b. FFY '04 $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Att. 4.19-A (Inpat. Hospital), pp. 1-55	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Att. 4.19-A (Inpat. Hospital), pp. 1-51

10. SUBJECT OF AMENDMENT:
Methods and Standards for Determining Payment Rates for Inpatient Hospital Services Provided by Non-State Owned Facilities

11. GOVERNOR'S REVIEW *(Check One)*:
x GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: // Mary B. Kennedy – signature //	16. RETURN TO: Stephanie Schwartz Minnesota Department of Human Services Federal Relations Unit 444 Lafayette Road No. St. Paul, MN 55155-3852
13. TYPED NAME: Mary B. Kennedy	
14. TITLE: Medicaid Director	
15. DATE SUBMITTED: March 24, 2003	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 6/22/03	18. DATE APPROVED: 6/2/03
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/03	20. SIGNATURE OF REGIONAL OFFICIAL: Brown for Sam
21. TYPED NAME: CHARLENE BROWN	22. TITLE: Deputy Director, CMSO

FORM HCFA-179 (07-92)

23. REMARKS:

MINNESOTA
MEDICAL ASSISTANCE
Federal Budget Impact of TN 03-02
Attachment 4.19-A: Inpatient Hospital Rate Methodology

1. Section 2. This State plan amendment amends the definition of the diagnostic categories under items A through E. The Department has revised the base year for the inpatient rates to more current data, effective January 1, 2003, according to Section 3.0. In this process, the Department reviewed the individual diagnosis related groups (DRGs) and in many circumstances has combined them into diagnostic categories based on costs to measure three items: 1) changes in resource consumption related to medical practice patterns and technology; 2) admission volume for statistical validity; and 3) services that are clinically coherent and homogeneous so as to be meaningful. The purpose of the diagnostic categories is to distribute the payment of services based on the historical cost of the services provided.

The changes in item E (pages 28-29) further clarify how payment is determined when it differs from the DRGs or is at risk for coding errors. It is necessary to isolate certain admission types with high resource utilization that are unique to the Medical Assistance populations. They include: 1) high volume cases; 2) cases with extended lengths of stay; and/or 3) services that are high cost.

These changes are not expected to have a fiscal impact for Federal Fiscal Years 2003 and 2004.

2. Section 3.00. Item B sets out how base years are established for hospitals that open after April 1, 1995. It is amended to apply only to long-term care hospitals. This is not a change to current practice.

3. Section 5.01. Item D, subitem (1) is amended to clarify current practice.

4. Section 5.03. Deleting the phrase "and speciality group" clarifies that an out-of-area hospital is not eligible for specialty group payment at either the rate for the rehabilitation distinct part or the rate for transfers to a neonatal intensive care unit. Deleting this phrase does not change current practice. There are several thousand hospitals in the country that come under the definition of an out-of-area hospital; it is therefore administratively difficult to verify which of these hospitals have a specialty group. Also, it is very uncommon for a service to be provided outside Minnesota's local trade area because one of the authorization requirements for out-of-state services is that the service is not available in Minnesota. Very few services are not available in Minnesota. Exceptions are made for emergencies or when a recipient's health would be endangered if the recipient was required to return to Minnesota. Furthermore, for authorized services, an out-of-area hospital has the option to negotiate payment under Section 15.06 according to state law, in lieu of the payment under this section.

The deletion and addition in item A are necessary for State plan changes added elsewhere in this State plan amendment. These changes require that a Minnesota or local trade area hospital have five or more admissions and five or more day outlier admissions in a base year to establish rates. Otherwise, a hospital will have its rate based on the metropolitan statistical or nonmetropolitan statistical average, depending on where the hospital is located.

Item A is amended to remove the reference to "in effect on the first day of a rate year." This change is needed so that a hospital's cost, rather than its rate, will be used in the calculation of the out-of-area hospital average rate. Current practice will not change.

This change is necessary because Attachment 4.19-A is being amended to permit a hospital with less than five admissions to no longer has its rate determined at its cost, but at the average metropolitan statistical area (MSA) or non-MSA rate (depending upon the hospital's location). Without this change, the calculation of the out-of-area hospital rate would be changed, because the calculation would use the rate rather than the cost for such a hospital.

The new language "determined in Sections 5.01 and 5.02" will continue the current practice of including each hospital's adjusted base year operating cost per admission (not its rate) with its corresponding number of admissions

regardless of the number of admissions in the calculation of the average rates.

5. Section 5.04. This section is amended to include the payment rates for low volume local trade area hospitals. Low volume local trade area hospitals have fewer than 20 Medicaid admissions in a base year, and thus do not qualify to have a rate established under that requirement. It is therefore necessary to establish a mechanism for determining a low volume local trade area hospital's rate. Because low volume local trade area hospitals are located in a metropolitan statistical area, it is reasonable to establish a rate according to the Minnesota metropolitan statistical area and local trade area hospital average rate because costs of similarly located hospitals are likely to be comparable.

Changes to this section and Section 5.05 require that a hospital have, by program, five or more admissions in the base year and, also by program, five or more day outlier admissions in the base year to qualify for payment rates that are based on its own costs rather than on a metropolitan or nonmetropolitan statistical average.

Requiring hospitals to have a specified minimum number of admissions as a condition of having a payment rate based on the hospital's actual costs is a necessary part of determining a cost-based rate that is statistically valid. Rate setting is based on averages, but a hospital that has an unusually low number of admissions in a base year may have its payment based on admissions and costs that were neither average nor representative. If a hospital's costs in the base year, as adjusted by case mix, are lower than is usually the case, the hospital will be underpaid. If the hospital's costs in the base year, as adjusted by case mix, are unusually high, the Medicaid Program will make an overpayment. In fact, it is quite possible that payments could be so high that they exceed the charges for services. Payments received in excess of charges must be paid back to the program. Paying back the program for overpayment could negatively affect a hospital's cash flow. A hospital, then, could be adversely affected by an underpayment as well as by an overpayment and the proposed amendment protects against both.

Using "at least five" as the number of admissions a hospital must have in a base year in order to have its rates set separately based on its costs is reasonable because five is a large enough number of admissions to create a statistically valid sample. At the same time, using five or more admissions is a low enough threshold that many hospitals, especially small rural hospitals, will be able to meet the requirement.

The deletion of "specialty group" is necessary because the rehabilitation distinct part specialty group average rate determination is in new Section 5.06.

Item A is amended to remove the reference to "in effect on the first day of a rate year." This change is needed so that a hospital's cost, rather than its rate, will be used in the calculation of the out-of-area hospital average rate. This identical change is discussed above, for Section 5.03.

The new language "determined in Sections 5.01 and 5.02" will continue the current practice of including each hospital's adjusted base year operating cost per admission (not its rate) with its corresponding number of admissions regardless of the number of admissions in the calculation of the average rates.

6. Section 5.05. The need for applying averages to nonmetropolitan statistical area hospitals that do not meet the requirement of five or more admissions in the base year is the same as that discussed in Section 5.04.

7. New Section 5.06. This section requires that a statewide average be calculated for hospitals that have a rehabilitation distinct part specialty group with fewer than five admissions in the base year. Of the approximately 160 Minnesota and local trade area hospitals, only about 20 have a rehabilitation distinct part. All but two of these hospitals are located in a metropolitan statistical area. It is illogical to establish a nonmetropolitan statistical area average for two hospitals. Therefore, it is reasonable to determine one average rate; that is, a Minnesota and local trade area rate for hospitals with a rehabilitation distinct part specialty group that do not have five or more admissions.

8. Section 6.02. The "five or more" admissions language is added for the reasons discussed in Section 5.04.

9. Section 6.03. This State plan amendment proposes to calculate the average of the Minnesota and local trade area hospitals. Current language requires that separate averages be calculated for the MSA and non-MSA areas. Current Section 6.02 determines the MSA and current Section 6.04 determines the non-MSA. However, current Section 6.02 has never been applicable, because all Minnesota and local trade area hospitals with neonatal intensive care units are located in a metropolitan statistical area. Deleting Section 6.03 does not change current practice.

If a non-MSA were to establish a neonatal intensive care unit, rates for a transfer to such a unit could not be determined for two reasons. First, the hospital would not have any Medical Assistance admissions in the current base year because there is a four-to-five year lag between a base year and a rate year. Because rebasing is conducted every two years, it would take at least several rebasings before the hospital could have claims in a base year so that rates could be determined based on its experience. Secondly, rates cannot be determined under current Section 6.02 because there are no non-MSA hospitals that have a neonatal intensive care unit. Therefore, it is reasonable to determine one average rate; that is, the Minnesota and local trade area hospital average rate with transfers to a neonatal intensive care unit specialty group that did not have five or more Medical Assistance admissions in the base year.

10. Section 6.04. The phrase "hospital admissions to" is deleted because it is unnecessary.

11. Section 6.05. It is necessary and reasonable to establish a rate per day for a long-term care hospital that does not have Medicaid (in this context, MA includes General Assistance Medical Care, a State-funded program) admissions in the base year according to the average of other long-term care hospitals as required under state law. The need for applying the average to long-term care hospitals that do not have five or more Medicaid admissions in the base is added for the reasons discussed in Section 5.04.

12. Section 8.02, item A. Item A is amended to remove the reference to "in effect on the first day of a rate year." This change is needed so that a hospital's cost, rather than its rate, will be used in the calculation of the out-of-area hospital average rate. This identical change is discussed above, for Section 5.03.

13. Section 8.03. This section is amended for the reasons discussed in Section 5.04.

14. Section 8.04. This section is amended for the reasons discussed in Section 5.05.

15. New Section 8.05. This new section is added for the same reasons as discussed in new Section 5.06.

16. Section 9.01. Item B is amended for the reasons discussed in Section 6.02.

17. Section 9.02. Item B is added for the reasons discussed in Section 6.05.

Current language is deleted because item A clarifies how the property cost per day is determined for long-term care hospitals.

18. New Section 15.13. Effective for admissions on or after March 1, 2003 and through June 30, 2003, except admissions paid under Section 15.07, the total payment, before third-party liability and spenddown, is reduced by five percent.

A summary of the savings follows. There is no federal budget impact due to the amended DRG definitions in Section 2 or the changes in Sections 3 through 9. The five percent payment reduction in Section 15.13 produces savings.

	(in 1000's) FFY '03*	FFY '04
Total cost	($2,166)	$0
FFP	50.00%	50.00%
Total MA Cost	($2,166)	$0
State share	($1,083)	$0
Federal share	**($1,083)**	**$0**

* January 1, 2003 through September 30, 2003. The five percent payment reduction runs through June 30, 2003.

The Department estimates that these changes will have no impact on recipients.

Methods and Standards for Determining Payment Rates for Inpatient Hospital Services Provided by Non-State Owned Facilities

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SECTION 1.0 PURPOSE AND SCOPE

The Minnesota inpatient hospital payment system under the Medical Assistance Program is authorized by state law. Payment rates are prospectively established on a per admission or per day basis under a diagnostic related group (DRG) system that condenses Medicare categories into Minnesota diagnostic categories. Rates are differentiated by eligibility (Medical Assistance, Minnesota Family Investment Program or MFIP, Medical Assistance non-MFIP) and specialty (Rehabilitation Distinct Part, Neonatal Transfer). The system provides for the payment of operating and property costs with additional payments including a disproportionate population adjustment and an appeals mechanism.

The rate setting methodology is based on the cost finding and allowable cost principles of the Medicare program. The rates are established for each calendar year using hospital specific Medical Assistance claims data and cost that is trended for inflation to the current year from a base year. Rates are rebased to more current data every two years.

The methodology described in this Attachment is effective for admissions occurring on or after October 25, 1993.

To be eligible for payment, inpatient hospital services must be medically necessary.

Minnesota has in place a public process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

SECTION 2.0 DEFINITIONS

Accommodation service. "Accommodation service" means those inpatient hospital services included by a hospital in a daily room charge. They are composed of general routine services and special care units. These routine and special care units include the nursery, coronary, intensive, neonatal, rehabilitation, psychiatric, and chemical dependency units.

Adjusted base year operating cost. "Adjusted base year operating cost" means a hospital's allowable base year operating cost per admission or per day, adjusted by the hospital cost index.

Admission. "Admission" means the time of birth at a hospital or the act that allows a recipient to officially enter a hospital to receive inpatient hospital services under the supervision of a physician who is a member of the medical staff.

Allowable base year operating cost. "Allowable base year operating cost" means a hospital's base year inpatient hospital cost per admission or per day that is adjusted for case mix and excludes property costs.

Ancillary service. "Ancillary service" means inpatient hospital services that include laboratory and blood, radiology, anesthesiology, electrocardiology, electroencephalography, pharmacy and intravenous therapy, delivery and labor room, operating and recovery room, emergency room and outpatient clinic, observation beds, respiratory therapy, physical therapy, occupational therapy, speech therapy, medical supplies, renal dialysis, and psychiatric and chemical dependency services customarily charged in addition to an accommodation service charge.

Base year. "Base year" means a hospital's fiscal year that is recognized by Medicare, or a hospital's fiscal year specified by the commissioner if a hospital is not required to file information with Medicare, from which cost and statistical data are used to establish rates.

Case mix. "Case mix" means a hospital's admissions distribution of relative values among the diagnostic categories.

Charges. "Charges" means the usual and customary payment requested by the hospital of the general public.

City of the first class. "City of the first class" means a city that has more than 100,000 inhabitants, provided that once a city is defined in such a manner, it can not be reclassified unless its population decreases by 25 percent from the census figures that last qualified the city for inclusion in the class.

Cost outlier. "Cost outlier" means the adjustment included in the relative value that is applied to the admission and outlier rates so that payment is adjusted for exceptionally high cost stays. The adjustment is applied to all admissions with an above average cost, including patients that have not yet attained the age of one in all hospitals and that have not yet attained the age of six in disproportionate population hospitals.

Cost-to-charge ratio. "Cost-to-charge ratio" means a ratio of a hospital's inpatient hospital costs to its charges for inpatient hospital services.

Day outlier. "Day outlier" means an admission where the length of stay exceeds the mean length of stay for neonate and burn diagnostic categories by one standard deviation, and in the case of all other diagnostic categories by two standard deviations.

Diagnostic categories. "Diagnostic categories" means the diagnostic classifications containing one or more diagnostic related groups (DRGs) used by the Medicare program. The DRG classifications must be assigned according to the base year program and specialty groups with modifications as specified in items A to E.

A. Diagnostic categories eligible under the Medical Assistance non-Minnesota family investment program. The following diagnostic categories are for persons eligible under Medical Assistance non-MFIP except as provided in items B, C or D:

DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed. CLINICAL MODIFICATIONS
A. Nervous System Conditions		
(1) ~~Treated with~~ Craniotomy, age > 17, and spinal procedures	001, 002, 004	
(2) ~~Treated with~~ Craniotomy, age 0-17, and cochlear implants	003, 049	049 includes procedures 20.96-20.98 only
(3) [Reserved for future use]		
(4) [Reserved for future use]		
(5) [Reserved for future use]		
(6) Nervous system neoplasms	010, 011	
(7) [Reserved for future use]		
(8) [Reserved for future use]		
(9) [Reserved for future use]		
(10) [Reserved for future use]		
(11) [Reserved for future use]		
(12) [Reserved for future use]		
(13) [Reserved for future use]		
(14) [Reserved for future use]		
(15) [Reserved for future use]		
(16) ~~Treated with other surgical procedures~~ Extracranial vascular procedures	~~004,~~ 005~~, 007~~	
(17) Peripheral, cranial, and other nerve procedure ~~without cc~~	007, 008	
(18) Other nervous system diseases treated without surgery	013, 015, 016, 017, 019	

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(19) Spinal disorders/injuries ~~and nervous system infection~~	009~~, 020~~	
(20) Specific cerebral vascular and cranial/peripheral nerve disorders	012, 014, 018~~, 019~~	
(21) ~~Degenerative disorders and nonspecific cerebral vascular disorders with cc~~	~~012, 016~~	
Nervous system infection	020	
(22) Seizure and headache	~~024-026~~ 024, 026	
(23) Traumatic stupor and coma > 1 Hr, and Coma <1 Hr, Age > 17 with CC	027, 028, 031	
(24) Viral meningitis, hypertensive encephalopathy, concussion age > 17 with CC, other stupor, and coma	021-023, 029~~, 031~~	
(25) Concussion, age 0-17 ~~and Age~~ or > 17 without CC	025, 032, 033	
(26) Stupor and coma, < 1 hr, age 0-17 and other disorders of the nervous system	030, 034, 035	
B. Eye Diseases and Disorders	036-048	
C. Ear, Nose, Throat, and Mouth Diseases and Disorders		
(1) ~~Treated with~~ Tonsillectomy/ adenoidectomy only or myringotomy	059, 060, 062	
(2) ~~Treated with myringotomy w/ tube insertion, age 0-17~~	~~062~~	
Miscellaneous ear, nose, and throat procedures	055, 058	
(3) Otitis media and URI	068-070	
(4) Dental and oral disorders	185-187	
(5) [Reserved for future use]		
(6) Other ear, nose, throat, and mouth conditions	~~049-058,~~ 049-054, 056, 057, 061, 063-067, 071-074, 168, 169	Codes in DRG 049 except 20.96-20.98
D. Respiratory System Conditions		
(1) ~~Treated with~~ Ventilator support < 96 hrs	475	excludes 96.72
(2) [Reserved for future use]		

(3) ~~Treated with~~ Ventilator support 96+ hrs	475	includes 96.72
(4) ~~Treated with~~ Tracheostomy except for face, mouth, and neck diagnoses	483	
(5) [Reserved for future use]		
(6) Respiratory neoplasms	082	
(7) [Reserved for future use]		
(8) [Reserved for future use]		
(9) [Reserved for future use]		
(10) ~~Treated with~~ Tracheostomy for face, mouth, and neck diagnoses	482	
(11) Simple pneumonia and pleurisy, age 0-17 and age > 17 without CC	090, 091	
(12) Major chest procedures and OR procedures with CC	075, 076	
(13) Major respiratory diseases and disorders treated without surgery	078, 079, 085, 087, ~~092~~, 101	
(14) Other OR procedures without CC	077	
(15) Specific respiratory system diseases and other diseases with CC	080, 081, 083, ~~085,~~ 088, 089, 092, 094, 099	
(16) Respiratory system diseases without CC and bronchitis age > 17	084, 086, 093, 095-097, 100, 102	

E. Circulatory System Conditions

(1) [Reserved for future use]		
(2) [Reserved for future use]		
(3) ~~Percutaneous cardiac~~ Permanent cardiac pacemaker and other ~~vascular~~ cardiovascular procedures	~~111, 112,~~ 114, 116-120, 479, 517, 518	
(4) Major cardiac surgeries and implantable defibrillator	104-106, 108, 514, 515	
(5) Other cardiac interventional and surgical procedures	107, 109, 110, 115	
(6) [Reserved for future use]		
(7) [Reserved for future use]		

(8)	[Reserved for future use]	
(9)	[Reserved for future use]	
(10)	Major cardiac disorders including uncomplicated acute MI, treated without surgery	~~122-125,~~ 122, 124, 125, 127, 129, 137, 138, 144
(11)	Acute MI and congenital heart disease with CC and endocarditis	121, 123, 126, 135
(12)	Other circulatory conditions	132-134, 136, 139-143, 145
(13)	Deep vein thrombophlebitis and peripheral vascular disorders	128, 130, 131
(14)	Percutaneous and other procedures for ~~vascular~~ circulatory diseases ~~and conditions~~	111, 113, 478, 516

F. Digestive System Diseases and Disorders

(1)	~~Treated with~~ Anal and stomal procedures	~~157-158~~ 157 - 159
(2)	~~Treated with~~ Hernia procedures	~~159~~ 160-163
(3)	~~Treated with~~ Appendectomy with ~~compl. Prn Dx~~ complicated principal diagnosis or CC	164-166
(4)	~~Treated with~~ Appendectomy without ~~compl. Prn Dx~~ complicated principal diagnosis or CC	167
(5)	~~Treated with~~ Other surgical procedure of digestive system	~~146-156, 170, 171,~~ 147, 149-151, 153, 155, 156
(6)	Esophagitis, ~~gastroent~~ gastroenteritis, or ~~misc.~~ miscellaneous digestive disorders~~, age > 17~~	182-183, 184
(7)	Other digestive system condition	~~172-181~~ 171, 175-181, 188-190
(8)	Other bowel, stomach, digestive OR procedure with CC	146, 148, 152, 154, 170